I. Introduction and Goal

The Quality Strategy for managed care organizations (MCOs) is a well-developed and systematic approach to planning, designing, monitoring, and assessing the quality and appropriateness of the MCOs' care delivery systems. The Department of Medical Assistance Services (DMAS) has dedicated managed care staff that are involved in contract monitoring and quality activities. The goal of the quality strategy is to improve DMAS' ability to meet priorities and to continuously provide timely, accessible, and quality managed care services offered to Medicaid recipients by all MCOs in a consistent and ongoing manner. The Medallion II program was created for the purposes of improving access to care, promoting disease prevention, and ensuring quality of care.

II. Process for Quality Strategy Development, Review and Revision

For the development of the quality strategy, the review and utilization of the MCO contract and waiver are important in this process. The previously developed quality strategy as well as the Centers for Medicare and Medicaid Services (CMS) State Quality Assessment and Improvement Strategies provide a reference in the creation of the new strategy. Throughout the year, if significant changes occur to the quality strategy as defined by DMAS or CMS, the State quality strategy will be revised. The state's definition of significant changes to the strategy would involve changes to information requirements, performance measures, performance improvement projects, and access requirements. The revision will occur in the following manner:

1. The plan will be revised by the quality team;
2. The plan will be reviewed internally by the Managed Care staff including the Managed Care Supervisor, the Division Director, and the Deputy Director;
3. The plan will be reviewed for public comment by the Managed Care Advisory Committee (MAC), by advocacy groups and sister agencies such as the Virginia Department of Health as well as posted on the DMAS website for review; and
4. The plan will be forwarded to CMS for approval.

The quality team includes various Managed Care staff that have expertise in areas such as contract management, compliance analysis, quality review, and policy analysis.

The quality team meets to monitor, review, and revise the quality strategy quarterly and more frequently throughout the year, if necessary.

Documents reviewed for the development of the quality strategy are as follows:

1. MCO contract and waiver;
2. Previously drafted quality strategy
3. CMS Guidelines (State Quality Assessment and Improvement Strategies);
4. EQRO technical support review and revision documents; and
5. BBA Managed Care Regulations.

Regular reports on the implementation and effectiveness of the quality strategy will be submitted to CMS at least annually.

III. Medicaid contract provisions

The provisions in the State's Medicaid MCO contract that incorporate the established standards for access to care, structure and operations, and quality measurement and improvement are stated and addressed throughout this quality strategy. Therefore, the MCO contract provisions that deal with quality issues are not restated in this section.

IV. State Standards for Access to Care

A. Summary Description of State Standards for Access to Care

1. Availability of Services – In order to ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, DMAS stipulates, through its contracting arrangements with the MCOs, the following requirements for the MCOs' delivery networks:

a. Article II, Section J.1.a. of the managed care contract requires MCOs to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, MCOs must consider all of the following: 1) the anticipated Medicaid enrollment; 2) the expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated Medicaid population to be served; 3) the number and type (in terms of training and experience and specialization) of providers required to furnish the contracted services; 4) the number of network providers not accepting new Medicaid patients; 5) the geographic location of providers and enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees; and 6) whether the location provides physical access for enrollees with disabilities.

b. Article II, Section G.34. states that MCOs must permit any female enrollee, age thirteen (13) or older, direct access to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without prior authorization from the primary care physician.

c. Article II, Section G.30.1. requires that MCOs provide coverage for a second opinion when requested by the enrollee for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. MCOs must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee. MCOs may require an authorization to receive specialty care from an appropriate provider; however, MCOs cannot deny a second opinion request as a non-covered service.

d. Article II, Section J.39. requires MCOs to cover and pay for services furnished in facilities or by practitioners outside the MCO's network if the needed medical services or necessary supplementary resources are not available in the MCO's network. The MCO must provide coverage out-of-network for any of the following circumstances: 1) when a service or type of provider is not available within the MCO's network; 2) for up to 30 days to transition the client to an in-network provider when a provider that is not part of the MCO's network has an existing relationship with the beneficiary, is the beneficiary's main source of care, and has not accepted an offer to participate in the MCO's network; 3) when the providers that are available in the MCO's network do not, because of moral or religious objections, furnish the service the client seeks; or 4) when DMAS determines that the circumstance warrants out-of-network treatment.

e. Article II, Section J.39. states that the MCO will cover and pay for all authorized care that it has pre-authorized and provided out of its established network. Out-of-network claims must be paid in accordance with the Medicaid fee schedule in place at the time the service was rendered or at another fee negotiated between the MCO and the provider of services. This provision in the contract ensures that the cost to the enrollee is no greater than it would be if the services were furnished within the network.

f. In order to comply with credentialing requirements, the contract states in Article II, Section L.5. that the MCO's QIP must contain the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the MCO or its subcontractor(s) are qualified to perform their medical or clinical services. The MCO must have written policies and procedures for the credentialing process that match the credentialing and recredentialing standards of the most recent guidelines from NCQA. The MCO's recredentialing process must include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and enrollee satisfaction surveys. Article II, Section K.2. states that provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If the MCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

Article II, Section K.6. of the contract stipulates that MCOs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

According to Article II, Section L.5., the MCO will perform an annual review on all subcontractors to ensure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under the contract. The

MCO must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license.

g. DMAS requires that the MCOs meet and require their providers to meet DMAS' standards for timely access to care and services. In Article II, Section J.10., the contract requires that enrollees in urban areas have a choice of at least two PCPs located within no more than thirty minutes travel time from any enrollee unless the MCO has a DMAS-approved alternative time standard. Enrollees in rural areas must have a choice of at least two PCPs located within no more than sixty minutes travel time from any enrollee unless the MCO has a DMAS-approved alternative time standard. MCOs must ensure that obstetrical services are available within no more than forty-five minutes travel time from any pregnant enrollee in rural areas unless the MCO has a DMAS-approved alternative time standard.

The MCO must ensure that each enrollee has a choice of at least two PCPs located within no more than a fifteen mile radius in urban areas and thirty miles in rural areas unless the MCO has a DMAS-approved alternative distance standard. The MCO must ensure that an enrollee is not required to travel in excess of thirty miles in an urban area and sixty miles in a rural area to secure initial contact with referral specialists, hospitals, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, and physicians, dentists, or other necessary providers unless the enrollee so chooses.

In Article II, Section J.9., the contract requires the MCO to maintain adequate provider network coverage to serve the entire eligible Medallion II populations in geographically accessible locations within the region twenty-four hours per day, seven days a week.

Article II, Section J.14. requires that MCOs establish a system to regularly monitor their provider networks to ensure compliance with access standards as set forth in the contract. When there is a failure to comply, corrective action must be taken. MCOs must also be prepared to demonstrate to DMAS that the access standards have been met.

h. In Article II, Section F., the contract states that the MCOs must participate in DMAS' efforts to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.

2. Assurances of adequate capacity and services – Article II, Section J. of the contract requires MCOs to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this contract. MCOs must meet the following network and access standards:

a. MCOs are solely responsible for arranging for and administering covered services to enrolled enrollees and must ensure that their delivery systems will provide available, accessible, and adequate numbers of facilities, locations, and personnel for the provision of covered services.

b. In order to maintain a network of providers that is sufficient in number, mix, and geographic distribution, the contract requires that MCOs comply with the following criteria for network development:

1) Enrollee-to-PCP Ratios – Article II, Section J.4. of the contract requires the MCO to have at least one full-time-equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Medicaid enrollees, and there must be one FTE PCP with pediatric training and/or experience for every 2,500 enrollees under the age of eighteen.

2) Specialist Services – Article II, Section J.5. of the contract specifies the type of specialists that are required to provide adequate covered services to Medallion II enrollees.

3) Enrollee-to-Dentist Ratios – Article II, Section J.6. of the contract requires that the MCO have no more than two thousand enrollees under the age of 21 years for each dental team in its network.

4) Inpatient Hospital Access – Article II, Section J.7. of the contract stipulates that the MCOs maintain in their networks a sufficient number of inpatient hospital facilities which is adequate to provide covered services to their enrollees.

c. Attachment V. Section C. of the MCO contract requires that new agreements and changes in approved agreements be reviewed and approved by DMAS before taking effect. According to Article II, Section J., the MCOs are required to notify DMAS within thirty business days of any changes to a network provider agreement made by the MCO, a subcontractor, or network provider regarding termination, pending termination, or pending modification in the subcontractor's or network provider's terms that could reduce enrollee access to care. After DMAS reviews the documentation submitted by the MCO, DMAS will certify to CMS that the MCO has complied with DMAS' requirements for availability of services. DMAS will also make available to CMS, upon request, all documentation collected by DMAS from the MCOs.

3. Coordination and continuity of care - Article II, Section L.2. of the MCO contract states that the MCOs are required to have systems in place that ensure coordinated patient care for all enrollees and provide particular attention to the needs of enrollees with complex, serious, and/or disabling conditions. The systems, policies, and procedures must be consistent with the most recent NCQA standards. Such systems must ensure the provision of primary care services, coordinated patient care, and access when necessary

to specialty care services/ providers. The MCO's coordination and continuity of care systems must include provisions for the following:

a. Enrollees must have an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

b. The MCO's system to coordinate patient care must include provisions to coordinate benefits and methods to prevent the duplication of services.

c. Article II, Section R.2.iv. of the contract requires that the MCOs provide care coordination for children with special health care needs among the multiple providers, agencies, advocates, and funding sources serving children with special health care needs.

d. Article II, Section L.2.c. stipulates that the MCO must ensure that the process utilized to coordinate the enrollee's care complies with enrollee privacy protections described in HIPAA regulations and in Title 45 CFR parts 160 and 164, subparts A and E, to the extent applicable.

e. The MCO contract provides for the following additional services for children with special health care needs:

i. Identification – Article II, Section R.1. of the contract identifies children with special health care needs (CSHCN) as those children under age 21 who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. CSHCN consist of children in the eligibility categories of SSI and Title V participation. DMAS provides to the MCOs a monthly report identifying all SSI and Title V children to enable the MCOs to identify and better serve CSHCN.

ii. Assessment – Article II, Section R.2. of the contract states that MCOs are required to make a good faith effort to conduct an assessment of all CSHCN, as identified by DMAS, within 90 days receipt of notification of Title V and SSI children. The MCOs are required to provide, on an annual basis, to DMAS a copy of the detailed policies and procedures for completion of assessments of CSHCN as well as a copy of the assessment tool used. The MCO's assessment mechanism must utilize appropriate health care professionals and must identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

iii. Care Coordination – Article II, Section R.2. iv. stipulates that the MCOs provide care coordination for CSHCN among the multiple providers, agencies, advocates, and funding sources serving CSHCN.

iv. Direct Assess to Specialists – Article II, Section R.2.v. requires the MCO to have a mechanism in place for recipients determined to have ongoing special conditions that require a course of treatment or regular care monitoring that allows the enrollee direct access to a specialist through a standing referral or an approved number of visits as appropriate for the enrollee's condition and identified needs.

4. Coverage and authorization of services – Article II, Section G.1. of the contract requires that MCOs provide, arrange for, purchase or otherwise make available the full scope of Medallion II services, with the exception of the carved-out services and other exceptions noted in this Article to which persons are entitled under the State Plan for Medical Assistance. In no case can the MCO establish more restrictive benefit limits for medically necessary services than those established by Medicaid. The MCOs must manage service utilization through utilization review, prior authorization, and case management, but not through the establishment of benefit limits for medically necessary services that are more restrictive than those established by Medicaid. In accordance with 42 CFR §438.210, MCOs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

a. The amount, duration, and scope of each service that the MCO is required to offer are listed in Article II, Section G., "Provision of Contract Services."

b. As defined in the contract, "medically necessary" means appropriate and necessary health care services that are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 CFR §440.230, services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Article II, Section G of the contract delineates the services that the MCOs are responsible for covering and stresses the importance of prevention, diagnosis, and treatment of health impairments, the ability of children, as part of EPSDT services, to achieve age-appropriate growth and development, and the ability of enrollees to attain, maintain, or regain functional capacity.

In Article II, Section G.43., the contract stipulates that the actual provision of any service is subject to the professional judgment of the MCO's providers as to the medical necessity of the service, except in situations in which the MCO must provide services ordered by DMAS pursuant to an appeal from the MCO's grievance process or an appeal directly to DMAS by an enrollee or for emergency services as defined in the contract. Decisions to provide authorized medical services required by the contract are based solely on medical necessity and appropriateness. Disputes between the MCO and enrollees about medical necessity may be appealed to DMAS by the enrollee or the enrollee's representative.

c. In Article II, Section L.4., the contract states that the MCOs must have a written utilization management (UM) program description, which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical services. In accordance with 42 CFR §438.210, the MCOs' UM program must ensure consistent application of review criteria for authorization decisions and must consult with the requesting provider when appropriate.

d. The contract stipulates in Article II, Section L.4. that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. In accordance with 42 CFR §438.210, the MCO must notify the requesting provider and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

B. Additional Information Related to the Access to Care Standards

1. Mechanisms the State Uses to Identify Persons with Special Health Care Needs

a. Identification – Article II, Section R of the contract identifies children with Special Health Care Needs (CSHCN) as those children under age 21 who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. CSHCN consist of children in the eligibility categories of SSI and Title V participation.

DMAS provides to the MCOs a monthly report that identifies all SSI and Title V children to enable the MCOs to identify and better serve CSHCN.

V. State Standards for Structure and Operations

A. Summary Description of the State Standards for Structure and Operations

1. Provider Selection and Retention– Article II, Section K. of the contract requires MCOs to provide adequate resources to support a provider relations function that will effectively communicate with existing and potential network providers. The MCO is required to give each network provider and potential network provider, upon request, instructions about the MCO's provider enrollment process, including enrollment forms, brochures, enrollment packets, provider manuals, and participating provider agreements.

The contract also requires that all providers receive proper education and training regarding the Medallion II managed care program. The MCO is required to conduct

education seminars and/or individual training for all providers within sixty calendar days after the MCO places a newly enrolled provider on active status. The MCO is also required to conduct ongoing training and education when deemed necessary by the MCO or DMAS.

a. Credentialing/Recredentialing Policies and Procedures – Article II, Section L. of the contract states that the MCO's QIP must contain the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the MCO or its subcontractor(s), as evidenced by signed contracts, are qualified to perform their medical or clinical services. MCOs are required to have written policies and procedures for the credentialing process that match the credentialing and recredentialing standards of the most recent guidelines from NCQA. The MCO's recredentialing process must include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and enrollee satisfaction surveys. The MCO is required to perform an annual review on all subcontractors to assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under the contract. The MCO must have in place a method for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license.

2. Enrollee Information – Article II, Section F. of the contract describes the communication standards required of MCOs contracting with the State. MCOs are required to participate in DMAS' efforts to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCO must ensure that documents for its membership such as the enrollee handbook are comprehensive yet written to comply with readability requirements. In addition, the MCO must make available enrollee handbooks in languages other than English when five percent of the MCO's enrolled population are non-English speaking and speak a common language. The MCO must institute a mechanism for all enrollees who do not speak English to communicate effectively with their PCPs and with MCO staff and subcontractors. In addition, oral interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education. The MCO also must provide TTY/TDD services for the hearing impaired.

Article II, Section D describes the information on interpretation and translation services that must be provided in the enrollee handbook for enrollees and potential enrollees, if requested: a) information on how to access oral interpretation services, free of charge, for any non-English language spoken, b) a multilingual notice that describes translation services that are available and provides instructions explaining how enrollees can access those translation services, and c) information on how to access the handbook in an alternative format for special needs individuals including, for example, individuals with visual impairments.

The MCO is required to provide to enrollees, prior to the first day of the month in which their enrollment starts, an information packet indicating the enrollees' first effective date of enrollment. At a minimum, the information packet must include: a) an introduction letter, b) a Medallion II identification card, c) a description of the service area and provider directory listing names, locations, telephone numbers, and non-English languages spoken by contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals. Additionally, this directory must identify any restrictions that could impact the enrollee's freedom of choice among network providers, d) evidence of coverage, and e) an enrollee handbook.

At a minimum, the enrollee handbook must include the following information: a) enrollee eligibility, b) choosing or changing an MCO, c) choosing or changing a PCP, d) making appointments and accessing care, e) enrollee services, f) emergency care, g) enrollee identification card, h) enrollee responsibilities, i) MCO responsibilities, j) grievances and appeals, k) interpretation and translation services, l) program or site changes, and m) additional information that is available upon request including information on the structure and operation of the MCO and physician incentive plans.

When there are program or service site changes, the MCO must ensure that affected enrollees are notified of any changes at least fourteen calendar days prior to their implementation.

Article II, Section K. describes the written policies and procedures that the MCOs must have in place related to provider disenrollment. For PCPs, there must be procedures to provide a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care from the terminated provider.

3. Confidentiality – Article IX, Section B. of the contract provides that except as otherwise required by law including, but not limited to, the Virginia Freedom of Information Act, access to confidential information must be limited by the MCO and DMAS to persons who or agencies which require the information in order to perform their duties related to the contract, including the U.S. Department of Health and Human Services; the Office of the Attorney General of the Commonwealth of Virginia, including the Medicaid Fraud Control Unit; and such others as may be required by DMAS. The MCOs and the Commonwealth must follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and recipients of public assistance, and 42 CFR Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records. The MCOs must have written policies and procedures for maintaining the confidentiality of data, including medical records and enrollee information and appointment records for the treatment of sexually transmitted diseases.

4. Enrollment and Disenrollment – As stated in Article III, Section B., DMAS has the sole responsibility for determining enrollment in the MCO's plan.

a) Disenrollment requested by the enrollee – According to Article II, Section D., an enrollee may disenroll from any MCO to another at any time, for good cause, as defined by DMAS. In addition, an enrollee may disenroll for any reason during the first ninety calendar days following the effective date of enrollment and at least once every 12 months thereafter. DMAS will inform enrollees of the opportunity to remain with the current MCO or change to another MCO without cause within sixty days prior to the end of the enrollment period. DMAS must also permit an enrollee to disenroll at any time for good cause. The request may be submitted orally or in writing to DMAS and cite the reason(s) why he or she wishes to disenroll such as poor quality care, lack of access to necessary specialty services, or other reasons satisfactory to DMAS. DMAS will respond to "good cause" requests in writing within 15 business days of DMAS' receipt of the request. If DMAS fails to make a determination by the first day of the second month following the month in which the enrollee files the request, the disenrollment request will be considered approved and effective on the date of approval. Article V, Section C. of the contract describes the circumstances under which an enrollee may request disenrollment due to intermediate sanctions imposed by the State as a result of non-compliance with the contract.

b) Article II, Section D. states that enrollees who have been previously enrolled with an MCO who regain eligibility for Medallion II enrollment within sixty (60) calendar days of the effective date of exclusion or disenrollment and who do not select another MCO will be reassigned to the MCO, as appropriate, (provided sufficient enrollee slots are available under the contract) and without going through the selection or pre-assignment process.

5. Grievance System – Article II, Section S. of the contract details the requirements for enrollee notices, grievances, and appeals procedures. The MCO is required to have in place a system to respond to inquiries, grievances, appeals, and claims received from enrollees. The MCO must ensure that enrollees are sent written notice of any adverse action that informs enrollees of their right to appeal through the MCO or through DMAS' State fair hearing system. As part of the contract monitoring process outlined in Article III, Section G., a review of the process of timely notification of action will be conducted by DMAS or its subcontractor at least annually.

The MCOs must provide grievance and appeal forms and/or written procedures to enrollees who wish to register written grievances or appeals and must provide reasonable assistance in completing forms and taking other procedural steps including providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

The MCO's grievance process must allow the enrollee, or the enrollee's authorized representative (provider, family member, etc.) acting on behalf of the enrollee, to file a grievance either orally or in writing. The MCO must acknowledge the receipt of each grievance. The MCO must also ensure that the individuals who make decisions on grievances were not involved in any previous level of review or decision-making. The MCO must ensure that the decision-makers are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease when the reason for the grievance involves clinical issues or relates to the denial of expedited resolution of an appeal.

The MCO is required to respond to all grievances as expeditiously as the enrollee's health condition requires, not to exceed thirty days from the date of initial receipt of the grievance. The grievance response must include the decision reached, the reason(s) for the decision, the policies or procedures that provide the basis for the decision, and a clear explanation of any further rights available to the enrollee.

Enrollees have the right to appeal any adverse action; the MCO must accept appeals submitted within thirty days from the date of notice of adverse action. The MCO must educate its enrollees of their right to appeal directly to DMAS at the same time that they appeal to the MCO, or after they have exhausted their appeal rights with the MCO, or instead of appealing to the MCO. Any adverse action or appeal that is not resolved wholly in favor of the enrollee by the MCO may be appealed by the enrollee or the enrollee's authorized representative to DMAS for a fair hearing.

The MCO's appeals process must require that the enrollee's benefits continue while the appeal or the State fair hearing is pending when all of the following criteria are met: a) The enrollee or the provider on behalf of the enrollee files the appeal within ten days of the MCO's mailing date of the notice of adverse action or prior to the effective date of the MCO's notice of adverse action; and b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and c) The services were ordered by an authorized provider; and d) The original period covered by the initial authorization has not expired; and e) The enrollee requests extension of benefits. If the final resolution of the appeal is adverse to the enrollee, the MCO may pursue recovery of the cost of services furnished to the enrollee while the appeal was pending, to the extent that the services were furnished solely because of the requirements listed above.

The MCO must respond in writing to standard appeals as expeditiously as the enrollee's health condition requires and must not exceed thirty days from the initial date of receipt of the appeal. The MCO may extend this timeframe by up to an additional fourteen calendar days if the enrollee requests the extension or if the MCO provides evidence satisfactory to DMAS that a delay in rendering the decision is in the enrollee's interest.

The MCO must also establish and maintain an expedited review process for appeals where either the MCO or the enrollee's provider determines that the time expended in a

standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The MCO must issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not to exceed three working days from the initial receipt of the appeal.

All decisions on appeals must be in writing and must include the following information: a) the decision reached by the MCO, b) the date of the decision, and c) for appeals not resolved wholly in favor of the enrollee, the right to request a State fair hearing and how to do so and the right to request to receive benefits while the hearing is pending and how to make the request explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.

The MCO must educate its enrollees of their right to appeal directly to DMAS. The enrollee has the right to appeal to DMAS at the same time that he/she appeals to the MCO or after appeal rights with the MCO have been exhausted or instead of appealing to the MCO. Any adverse action or appeal that is not resolved wholly in favor of the enrollee by the MCO may be appealed by the enrollee or the enrollee's authorized representative to DMAS for a fair hearing. If an enrollee wishes to file an appeal with DMAS, the appeal must be filed in writing within thirty days of the enrollee's receipt of notice of any action to deny, delay, terminate, or reduce a service authorization request or to deny payment for Medicaid/FAMIS Plus covered services unless good cause exists.

6. Subcontractural relationships and delegation – Article II, Section B. of the contract requires that all subcontracts entered into must meet the following delegation requirements: 1) All subcontracts must be in writing; 2) Subcontracts must fulfill the requirements of the contract and applicable Federal and State laws and regulations; 3) Subcontracts must specify the activities and reporting responsibilities delegated to the subcontractor; and 4) Subcontracts must have provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate.

a. DMAS holds the MCO accountable for all actions of the subcontractor and its providers. All subcontracts entered into must meet the following delegation and monitoring requirements: 1) The MCO must perform on-going monitoring of all subcontractors; 2) The MCO must perform a formal review of all subcontractors at least annually; and 3) As a result of monitoring activities conducted by the MCO, the MCO must identify to the subcontractor deficiencies or areas for improvement and must require the subcontractor to take appropriate corrective action.

All subcontracts must ensure the level and quality of care required under the contract. Subcontracts with the MCO for delegated administrative and medical services must be submitted to DMAS at least thirty days prior to their effective date. All subcontracts are subject to DMAS's written approval, and DMAS may revoke such approval if DMAS determines that the subcontractors fail to meet the requirements of the contract.

B. Additional Information Related to Structure and Operation

1. State Procedures for the Review of the Records of MCO Grievances and Appeals and for Identifying and Resolving Systemic Problems

a. As stated in Article II, Section S. of the contract, the MCOs must submit to DMAS by the fifteenth day of the month after the end of each month, a mutually agreed upon summary report of inquiries, grievances, and appeals and a log of grievances and appeals filed by enrollees.

b. Grievance and appeal categories identified must be organized or grouped by the following general guidelines: 1) access to health services, 2) utilization and medical management decisions, 3) provider care and treatment, 4) payment and reimbursement issues, and 5) administrative issues.

c. The log must contain the following information for each grievance or appeal: 1) the date of the communication, 2) the enrollee's Medicaid identification number, 3) whether the grievance or appeal was written or oral, 4) indication of whether the dissatisfaction was a grievance or an appeal, 5) the category of each inquiry, 6) a description of subcategories or specific reason codes for each grievance and appeal, 7) the resolution, and 8) the resolution date.

VI. State standards for quality measurement and improvement

A. Summary Description of State Standards for Quality Measurement and Improvement

1. Practice guidelines – Article II, Section L.6. of the contract describes the practice guidelines that MCOs are required to establish. The guidelines must be congruent with current NCQA standards and must meet the following requirements:

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a. The practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.
b. The guidelines must consider the needs of enrollees;
c. The practice guidelines are adopted in consultation with contracting health care professionals; and
d. The guidelines are reviewed and updated periodically, as appropriate.

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MCOs are required to disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Additionally, the MCOs must provide a copy to DMAS on an annual basis. MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.

2. Quality assessment and performance improvement program

a. Conduct performance improvement projects – As stated in Article II, Section L., MCOs that contract with State Medicaid agencies are required to have an internal quality improvement program (QIP). Such QIP must meet the accreditation standards of NCQA. The MCOs are encouraged to perform all HEDIS performance measures for the Medicaid product as a part of the quality improvement (QI) program. In addition, MCOs are required to complete, at a minimum, the following eleven HEDIS performance measures annually:

1. Childhood Immunization Status
2. Adolescent Immunization Status
3. Breast Cancer Screening
4. Prenatal and Postpartum Care
5. HEDIS/CAHPS Adult Survey
6. Well-Child Visits in the First 15 Months of Life
7. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
8. Adolescent Well-Care Visit
9. Comprehensive Diabetes Care
10. Asthma-Appropriate Use of Medication
11. Beta Blocker Treatment After a Heart Attack

Each MCO is required to conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. MCOs must have ongoing quality assessment and performance improvement projects. Programs must meet requirements of NCQA, which include:

1. Collect and analyze data to measure performance against standards;
2. Measures include those that assess access, appropriateness and quality of care, including administrative and clinical measures;
3. Implement interventions to improve performance; and
4. The effectiveness of the program is measured.

The MCO's QIP must consist of systematic activities to monitor and evaluate the care delivered to enrollees according to predetermined, objectives standards and to make improvements as needed. The MCOs are required to correct significant systemic problems that come to their attention through internal surveillance, complaints, or other mechanisms. The MCOs must ensure that their grievance system is tied to their quality improvement program.

b. Submit performance improvement data – Article II, Section L. of the contract requires the MCOs to send to DMAS (annually or upon request) a copy of its quality improvement program and prior year's outcomes, including results of HEDIS, and other performance measures, quality studies, and other activities as documented in the QIP. Results must reflect completion dates. In addition, the MCOs are required to cooperate with and ensure the cooperation of network providers and subcontractors with the

external quality review organization (EQRO) contracted by DMAS to perform quality studies to include providing timely access to recipients' medical records in DMAS' requested format.

c. Over-utilization and under-utilization of services – As stated in Article II, Section L. of the contract, each MCO must have in effect mechanisms to detect both under-utilization and over-utilization of services. The Medallion II contract mandates monitoring utilization trends for atypical medications.

All plans conduct their own internal monitoring for over and under utilization of services. These services may include inpatient admissions, pharmacy, emergency room utilization, referrals to specialists, certain procedures or surgeries, etc. MCOs may also monitor key indicators from HEDIS measurements. Monitoring is to be done on a set schedule that can be monthly, quarterly, or annually. Actions taken by the plans are dependent upon the findings of these reports or monitoring mechanisms.

Some of the types of measurements used are denial rates (to identify patterns) and comparisons to benchmarks or the MCO's target goals. Outcomes that are identified as potential problems are usually taken before the medical management departments or certain relevant committees for evaluation and resolution planning. Outcomes of over or under utilization may lead to newly developed policies and procedures in the identified problem areas.

d. Quality and appropriateness of care - Each MCO must have in place mechanisms to assess the quality and appropriateness of care furnished to all enrollees.

1. The MCOs must have in place monitoring mechanisms to ensure that recipients receive their needed services. **Formatted:** Bullets and Numbering

2. The MCOs are required to assess the quality of care to children with special health care needs in the areas of program development, enrollment procedures, provider networks, care coordination, and access to specialists. **Formatted:** Bullets and Numbering

3. Mechanisms used for their assessments include: involving stakeholders, consumers, or advocates in the planning of programs; collecting data through surveys; identifying and providing children with special health care needs with a "medical home"; providing care coordination and/or case management services to recipients identified with special needs; and allowing enrollees direct access to a specialist by means of standing referrals, an approved number of visits, or allowing the specialist to act as the primary care physician. **Formatted:** Bullets and Numbering

4. All MCOs utilize case managers as a key component to identifying, monitoring, and evaluating services for enrollees with special health care needs. **Formatted:** Bullets and Numbering

5. Most MCOs utilize their medical management and quality departments or committees specific to these areas to evaluate programs and authorizations for **Formatted:** Bullets and Numbering

enrollees, identify problem areas, and develop policies and procedures to address those problem areas.

6. Monitoring is done through the CAHPS Survey from MCOs and EQRO clinical focus studies. The MCOs are required to make a good faith effort to conduct an assessment of all CSHCN, as identified and reported by DMAS, within 90 days receipt of notification of Title V and SSI children. The MCOs must provide, on an annual basis, to DMAS a copy of the detailed policies and procedures for completion of assessments of CSHCN as well as a copy of the assessment tool used. The MCO's assessment mechanism must utilize appropriate health care professionals and must identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

7. The MCOs must assess the quality of care of CSHCN in the following areas:
   a. Program Development- Involve stakeholders, advocates, providers, and/or consumers, as applicable, in creating a program to support families of children with disabilities.

   b. Enrollment Procedures- Identify and collect data on children with special needs through surveys to assess the quality, appropriateness of, experience of, and satisfaction with the care provided to children and adolescents with special health care needs.

   c. Provider Networks- Assure the availability of providers who are experienced in serving children with special needs and provide a "medical home" that is accessible, comprehensive, coordinated, and compassionate.

   d. Care Coordination- Provide care coordination for CHSCN among multiple providers, agencies, advocates, and funding sources serving CSHCN.

   e. Access to Specialists- The MCOs must have a mechanism in place for recipients determined to have ongoing special conditions that require a course of treatment or regular care monitoring and that allows the enrollee direct access to a specialist through a standing referral or an approved number of visits as appropriate for the enrollee's condition and identified needs.

e. Performance measurement - Each MCO is required to complete and submit annually to DMAS the following HEDIS performance studies:

1. Childhood Immunization Status
2. Adolescent Immunization Status
3. Breast Cancer Screening
4. Prenatal and Postpartum Care
5. HEDIS/CAHPS Adult Survey
6. Well-Child Visits in the First 15 Months of Life

7. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
8. Adolescent Well-Care Visit

f. Reporting of the status and results of each project – DMAS monitors performance measures through the annual submission of each MCO's quality improvement plan and results from the previous year's quality improvement activities. DMAS receives the results of HEDIS and CAHPS measures from all MCOs as well as each MCO's JCAHO or NCQA accreditation report for use in monitoring access, quality, and timeliness of services provided to recipients.

Additionally, the EQRO performs an annual evaluation of each MCO's ability to provide timely and accessible quality services through analysis of aggregated performance measurement data, performance improvement projects undertaken by the MCO, focused clinical and non-clinical studies, and structural and operational accreditation activities.

g. Annual Review - The State must review, at least annually, the impact and effectiveness of each MCO's QIP. The review must include the MCO's performance on the standard measures on which it is required to report and the results of each MCO's QI projects.

1. The MCOs must send to DMAS (annually) a copy of its quality improvement program and prior year's outcomes, including results of HEDIS and other performance measures, quality studies, and other activities as documented in the QIP.
2. Results must reflect completion dates.
3. Monitoring is conducted by annual review of quality improvement plan, results, and HEDIS results by DMAS in conjunction with the EQRO.

3. Health Information Systems

As stated in Article II, Section O. of the contract, MCOs are required to have in place management information systems capable of furnishing DMAS information about the Medallion II program. Such information systems must be able to:

a. Collect data on enrollee and provider characteristics – MCO information systems must be able to accept and process enrollment reports, provider claims, and encounter data and must be able to track provider network composition and access as well as grievances and appeals.

b. Ensure data received from providers is accurate and complete by:

1. Verifying the accuracy and timeliness of reported data;
2. Screening the data for completeness, logic, and consistency; and
3. Collecting service information in standardized formats.

c. Make all collected data available to the State and upon request to CMS. - MCOs are required to report:

- Complaints, grievances, and appeals monthly
- HEDIS results annually
- EPSDT services annually
- Submit encounter data monthly
- Hospital inpatient days for adults, pediatric, nursery, neonatal intensive care, psychiatric, and rehabilitation monthly
- Inpatient authorizations and denied days monthly
- Sentinel events monthly
- Live birth outcomes reports quarterly
- Baby care enrollment reports
- Monthly operational reports
- Provider networks quarterly
- Operation reports of claims payments

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The State utilizes the above reports to monitor MCO operations, to evaluate patterns of care, and for ad hoc analyses. Stringent encounter data testing by the State's fiscal intermediary ensures that the data submitted by the MCOs are complete and accurate.

VII. State monitoring and evaluation

A. Arrangements for external quality reviews

DMAS contracts with an EQRO, that meets the federal guidelines for an EQRO, to conduct an annual analysis and evaluation of each MCO's ability to provide timely, accessible, quality services to Medicaid recipients.

In the conduct of the external quality review (EQR), the EQR may utilize documentation and/or methods from multiple sources, which may include, but not be limited to:

1. Licensure, Insurance, Other Legal Requirements
2. Credentialing of Providers
3. Confidentiality and Security
4. Medical records content/retention
5. Member education/Prevention programs
6. Provider payments
7. Cultural competency
8. Enrollment/Disenrollment timeliness
9. Grievances/Appeals
10. Network monitoring reports
11. Sentinel Events
12. Coordination and continuation of care
13. Contract evaluation/MCO Monitoring Log/Encounter data

14. Quality Assurance Plan
15. MCO accreditation, audit, and consumer and provider survey reports
16. MCO staff interviews

The annual External Quality Review (EQR) analysis and evaluation must be conducted in a manner consistent with the protocols for EQR of Medicaid Managed Care Organizations developed by CMS, and will consist of the following components:

1. Validation of performance improvement projects required by the State to comply with requirements set forth in 42 CFR §438.240(b)(1) that were underway during the preceding 12 months.

2. Validation of MCO performance measures reported (as required by the State) or MCO performance measures calculated by the State during the preceding 12 months to comply with requirements set forth in 42 CFR §438.240(b)(2).

3. A review, conducted within the first year of this contract, and at least every three years thereafter, to determine the MCO's compliance with standards (except with respect to standards under 42 CFR §438.240(b)(1) and (2), for conducting performance improvement projects and calculations of performance measures, respectively) established by the State to comply with the requirements of 42 CFR §438.204(g).

4. Conduct quality studies that focus on clinical and/or non-clinical aspects of care that have been determined to be of importance in monitoring access, quality, and timeliness of services provided to Medicaid recipients. The topics of these studies will be determined by DMAS annually.

5. Article II, Section L. of the contract requires MCOs to prepare a cumulative annual report summarizing the quality of services furnished to Medicaid recipients by each MCO under contract with DMAS. The report must synthesize the findings from the performance improvement projects, the performance measures, the compliance review and any focused clinical and/or non-clinical studies conducted within the previous twelve months. The annual report includes MCO-specific profiles as well as a statewide picture. The annual report summarizes the status of the Medallion II program in terms of progress made over the year and opportunities for improvement. Annually DMAS in conjunction with the EQRO will develop a scoring methodology to be utilized in determining each MCOs level of compliance with managed care regulations.

B. Nonduplication of mandatory external quality review activity

All plans are nationally accredited by either NCQA or JCAHO. DMAS and the EQRO will review all accreditation standards applicable to the MCOs and will determine which areas are duplicative. Currently, a crosswalk of the BBA, JCAHO, and NCQA standards is being developed by our EQRO and will provide guidance in this process. Once the crosswalk document and the rationale for why the State review would be

duplicative of review activity already performed are completed, a copy of the document will be provided to CMS for review.

VIII. Procedures for race, ethnicity, and primary language

DMAS has implemented a new MMIS and DSS/ADAPT system that will allow for the provision of demographic information to the MCOs at the time of enrollment. Implementation of the MMIS took place on June 16, 2003. Currently, information of this nature is provided in a separate file for each health plan. More detailed information on this process will be provided once the system has been active for a few months. As of August 2003, the revised Virginia Medicaid application is in effect and includes questions on race, ethnicity, and language. Applicants are not required to answer questions on race and ethnicity. At the time of application for the Virginia Medicaid program, potential recipients are given the opportunity to indicate their race, ethnicity and language. By federal law these are voluntary fields included in the application, but the information is collected when provided.

IX. National performance measures and levels

At this time, no performance measures and levels have been developed by CMS in consultation with the States and other relevant stakeholders. Once the national performance measures and levels have been identified, DMAS will incorporate them into the MCO contracts.

X. Intermediate Sanctions

DMAS places particular emphasis on prompt, accurate, and complete compliance with requirements related to access to medical services. MCOs may expect the prompt imposition of stringent remedies for failure to comply with contractual requirements. Remedies available to DMAS include:

A. Federally-Prescribed Sanctions for Noncompliance

1. Section 1932(3)(1)(A) of the Social Security Act (the Act) describes the use of intermediate sanctions for States. Section 1932(e)(2)(A) of the Act allows the State to impose civil money penalties. Article V, Section C.1. of the contract describes the noncompliance issues and the resulting applicable sanctions that may be imposed:

a. Sanctions may be imposed if the MCO fails to substantially provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract.

For each determination that the managed care organization (MCO) fails to substantially provide medically necessary services, a maximum of $25,000 in civil penalties may be imposed by the State.

b. Sanctions may be imposed if the MCO acts to discriminate against enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX of the Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services.

For each determination that the MCO discriminates against enrollees on the basis of their health status or requirements for health care services or engages in any practice that has the effect of denying or discouraging enrollment with the entity by eligible individuals based on their medical condition or history that indicates a need for substantial future medical services, a maximum of $100,000 in civil penalties may be imposed by the State.

For each determination that the MCO has discriminated against enrollees or engaged in any practice that has denied or discouraged enrollment, the money penalty may be as high as $15,000 for each individual not enrolled as a result of the practice, up to a maximum of $100,000.

2. Section 1932(e)(2)(B) of the Act specifies the conditions for appointment of temporary management. Article V, Section C.1. of the contract states:

a. Temporary management is imposed if the State finds that there is continued egregious behavior by the MCO or there is substantial risk to the health of the enrollees. Temporary management may also be imposed if there is a need to assure the health of the organization's enrollees during an orderly termination or reorganization of the MCO or while improvements are made to correct violations.

b. Once temporary management is appointed, it may not be removed until it is determined that the organization has the capability to ensure that the violations will not recur.

3. Sections 1932(3)(2)(C), (D), and (E) of the Act describe other sanctions that may be imposed. Article V, Section C.1. of the contract states:

a. The State may permit individuals enrolled in a managed care entity to disenroll without cause.

b. The State may suspend or default all enrollments of Medicaid beneficiaries after the date the Secretary of Health and Human Services or the State notifies the entity of a violation determination under Section 1903(m) or Section 1932 (e) of the Act.

c. The State may suspend payment to the entity under Title XIX for individual enrollees after the date the Secretary of Health and Human Services or the State

notifies the entity of the determination and until the entity has satisfied the Secretary or the State that the basis for such determination has been corrected and will not likely recur.

4. Section 1932(e)(3) of the Act specifies that if an MCO has repeatedly failed to meet the requirements of Section 1903(m) or Section 932(e) of the Act, the State must (regardless of what other sanctions are provided) impose temporary management and allow individuals to disenroll without cause.

5. Section 1932 (e)(4) of the Act allows the State to terminate contracts of any managed care entity that has failed to meet the requirements of Section 1903(m), 1905(t)(3), or 1932 (e) of the Act and enroll the entity's enrollees with other managed care entities or allow enrollees to receive medical assistance under the State Plan other than through a managed care entity.

B. Other Specified Remedies

Article V, Section C.1. of the contract states that if DMAS determines that the MCO failed to provide one or more of the contract services required under the contract, or that the MCO failed to maintain or make available any records or reports required under the contract by DMAS which DMAS may use to determine whether the MCO is providing contract services as required, the following remedies may be imposed:

1. Suspensions of New Enrollment

DMAS may suspend the MCO's right to enroll new Medicaid participants (voluntary, automatically assigned, or both) under the contract. DMAS may make this remedy applicable to specific populations served by the MCO or the entire contracted area. DMAS may also suspend new enrollment or disenroll recipients in anticipation of the MCO not being able to comply with any requirements of the contract or with Federal or State laws or regulations at its current enrollment level.

DMAS may also notify enrollees of the MCO's non-compliance and provide such enrollees an opportunity to enroll with another MCO.

2. Department-Initiated Disenrollment

DMAS may reduce the number of current enrollees. The MCO will be given at least thirty calendar days notice prior to DMAS taking any action set forth in this paragraph.

3. Reduction in Maximum Enrollment Cap

DMAS may reduce the maximum enrollment level or number of current enrollees. The MCO will be given at least thirty calendar days notice prior to DMAS taking any action.

4. Suspension of Marketing Services and Activities

DMAS may suspend an MCO's marketing activities, which are geared toward potential enrollees. The MCO will be given at least ten calendar days notice prior to DMAS taking any action set forth in the contract.

C. Withholding of Capitation Payments and Recovery of Damage Costs

DMAS may withhold portions of capitation payments or otherwise recover damages from the MCO in the following situations:

1. Whenever DMAS determines that the MCO has failed to provide one or more of the medically necessary Medallion II covered contract services, DMAS may direct the MCO to provide such service or withhold a portion of the capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money DMAS must pay to provide such services.

2. Whenever DMAS determines that the MCO has failed to perform an administrative function required under the contract, DMAS may withhold a portion of future capitation payments to compensate for the damages, which this failure entails. (Administrative function is defined as any contract service.)

D. Probation

In Article V, Section C.1., the contract stipulates that DMAS may place an MCO on probation, in whole or in part by providing the MCO with a written notice explaining the terms and the time period of the probation. The MCO must provide services in accordance with the terms set forth and will continue to do so for the period specified or until further notice.

E. Suspension of Contractor Operations

DMAS may suspend an MCO's Medallion II operations, in whole or in part, if DMAS determines that it is in the best interest of Medallion II recipients to do so.

F. Remedial Actions

Article V, Section C.1. of the contract states that DMAS may pursue all remedial actions with the MCO that are taken with Medicaid fee-for-service providers.
DMAS will work with the MCO and the MCO's network providers to change and correct problems and will recoup funds if the MCO fails to correct a problem within a timely manner.

G. Remedies not Exclusive

The remedies available to DMAS are in addition to all other remedies available to DMAS in law or in equity, are joint and severable, and may be exercised concurrently or consecutively.